SECTION 1915(c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   ____ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a. X aged (age 65 and older)

   b. X disabled

   c. ____ aged and disabled

   d. ____ mentally retarded

   e. ____ developmentally disabled

   f. ____ mentally retarded and developmentally disabled

   g. ____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

   a. ____ Waiver services are limited to the following age groups (specify):

   b. ____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d.____ Other criteria. (Specify):

e.__X__ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a.____ Yes b.__X__ No

7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a.____ Yes b.____ No c.__X__ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.____ Yes b.__X__ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.____ Yes b.__X__ No

If yes, waiver services will be furnished only to individuals in the following geographic or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.__X__Case management

b.__X__Homemaker

c.____ Home health aide services

d.__X__Personal care services

e.__X__Respite care

f.__X__Adult day health

g.____ Habilitation

____ Residential habilitation

____ Day habilitation

____ Prevocational services
____ Supported employment services

____ Educational services

h.____ Environmental accessibility adaptations

i.____ Skilled nursing

j.____ Transportation

k.____ Specialized medical equipment and supplies

l.____ Chore services

m.____ Personal Emergency Response Systems

n.__X__Companion services

o.____ Private duty nursing

p.____ Family training

q.____ Attendant care

r.____ Adult Residential Care

____ Adult foster care

____ Assisted living

s.____ Extended State plan services (Check all that apply):

____ Physician services

____ Home health care services

____ Physical therapy services

____ Occupational therapy services

____ Speech, hearing and language services
____ Prescribed drugs

____ Other (specify):

t. __X__ Other services (specify): Home Delivered Meals

u.____ The following services will be provided to individuals with chronic mental illness:

____ Day treatment/Partial hospitalization

____ Psychosocial rehabilitation

____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid Agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a.____ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b.__X__Meals furnished as part of a program of adult day health services.

c.____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid Agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. ____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ____ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of October 1, 2002 is requested.

19. The State contact person for this request is Priscilla Miles, who can be reached by telephone at (334) 242-5658.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and Attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid Agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid Agency.

Signature:
Print Name:
Title:
Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____The waiver will be operated directly by the Medical Assistance Unit of the Medicaid Agency.

X The waiver will be operated by ADPH & ADSS*, a separate agency of the State, under the supervision of the Medicaid Agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

____The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid Agency.

*Alabama Department of Public Health and Alabama Department of Senior Services

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. _X_ Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

_X_ Other Service Definition (Specify):

See Attached Scope of Service

b._X_ Homemaker:

_____Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_X_ Other Service Definition (Specify):

See Attached Scope of Service

c.___ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d._X_ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_X_ Payment will not be made for personal care services furnished by a member of the individual's family.

___ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

___ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

X A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

___ Case managers

___ Other (Specify):

3. Frequency or intensity of supervision (Check one):

___ As indicated in the plan of care

X Other (Specify):

Provide in-home supervision as needed, but at a minimum of every 60 days.

4. Relationship to State plan services (Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

X Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

X Other service definition (Specify):
Personal care must be provided by an individual that is qualified and employed by a certified HHA or other health care agencies; approved by the Commissioner of the Alabama Medicaid Agency. (Please See Scope of Service Definition).

e. X Respite care:

___ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (Specify):

Payment will not be made for respite care furnished by a member of the recipient's family; may not exceed 720 hours or 30 days per waiver year (October 1 through September 30); must not be used to provide continuous care while the primary caregiver is employed.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence

___ Foster home

___ Medicaid certified Hospital

___ Medicaid certified NF

___ Medicaid certified ICF/MR

___ Group home

___ Licensed respite care facility

___ Other community care residential facility approved by the State that its not a private residence (Specify type):

_X_ Other service definition (Specify):

See Attached Scope of Service

f._X_ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2.___No

_X_ Other service definition (Specify):

See Attached Scope of Service Definition

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.____ Habilitation:

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

___ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such

as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual

receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.___Yes 2.___No

___ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h.____ Environmental accessibility adaptations:

_____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

___ Other service definition (Specify):

i.____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

j.____ Transportation:

___ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

___ Other service definition (Specify):

k.____ Specialized Medical Equipment and Supplies:

____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

l.___ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

m.___ Personal Emergency Response Systems (PERS)

___ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

n.__X__ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This

service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

__X__ Other service definition (Specify):

See Scope of Service Definition

o.____ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.____ Family training:

_____ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.____ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

___ Other service definition (Specify):

r.___ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes

maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy

___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

- Home Delivered Meals (See Scope of Service Definition)

t.___ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other State plan services (Specify):

u.___ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level.

Specific psychosocial rehabilitation services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	C
Case Management	Case Manager Nurse or Case Manager SW	State Licensure Required NA	NA	S C S
Homemaker	Homemaker	X	NA	S C S
Respite Skilled and Unskilled	Approved Home Health Vendor Respite Care Worker	Skilled Respite Requires State Licensure Not Applicable for Unskilled Respite Care Worker	NA	S C S
Adult Day Health	Adult Day Health Provider	NA	Alabama Medicaid Agency Certification Required	S C S
Personal Care	Approved Home Health Vendor Personal Care Assistant	NA	NA	S C S
Adult Companion Service	Companion Worker	NA	NA	S C S

SERVICE	PROVIDER	LICENSE	CERTIFICATION	C
Home Delivered Meals	Approved Home Delivered Meal Provider	State of Alabama Business License	NA	S C S

SCOPE OF SERVICE DEFINITIONS

SCOPE OF SERVICE
FOR
CASE MANAGEMENT SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Case Management is an activity which assists individuals in gaining access to appropriate, needed, and desired waiver and other State Plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case Management Service may be used to locate, coordinate, and monitor necessary and appropriate services.

Case Management Service may also serve to provide necessary coordination with providers of non-medical, non-waiver services when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case Managers are responsible for ongoing monitoring of the provision of waiver and non-waiver services included in the individual's Plan of Care. Case Management is a waiver service available to all Elderly and Disabled (E/D) Waiver clients.

B. Objective

The objective of Case Management is to assist clients to make decisions regarding long term care. It also ensures continued access to waiver and non-waiver services that are appropriate, available, and desired by the client.

C. Description of Service to be Provided

The unit of service will be one (1) hour beginning on the date that the client is determined eligible for E/D Waiver Services and is entered into the Medicaid Long Term Care (LTC) file. Case Management Service provided prior to waiver approval should be considered administrative. At least one face to face visit is required monthly in addition to any other Case Management activities.

1. Within the context of home and community-based services, Case Management Service may include, but is not limited to, the following functions:

   a. Conducting assessments of need and necessity for waiver services;

   b. Completing and processing level of care applications for admission,

readmission, or redetermination of eligibility;

c. Developing, monitoring, and revising the client's Care Plan in coordination with the client/caregiver;

d. Arranging and authorizing waiver services according to the client's Care Plan;

e. Making referrals and assisting clients to gain access to needed Medicaid State Plan and other non-waiver services;

f. Coordinating the delivery of waiver and non-waiver services included in the client's Care Plan;

g. Monitoring the quality and effectiveness of waiver and non-waiver services provided to the client;

h. Making at a minimum, a monthly face-to-face visit with every active waiver client to monitor the Plan of Care;

i. Monitoring the cost effectiveness of waiver services for an individual;

j. Processing transfers from county-to-county or from Operating Agency to Operating Agency;

k. Facilitating transfers to or from other home and community-based waiver programs or other types of long term care;

l. Reinstating E/D Waiver Services following a client's short-term nursing home stay or admissions to another type of long term care;

m. Processing terminations of waiver eligibility and services;

n. Establishing and maintaining case records.

2. Prior to waiver approval, all potential clients are screened by the Case Manager to access their possible eligibility and to determine their desire for waiver participation. The intake screening activities and eligibility determination are distinct from Direct Case Management but are included in this scope of service since they are preliminary activities necessary for waiver enrollment. Case Management provided to a client prior to waiver approval is considered administrative.

Medicaid will not reimburse for activities performed which are not within the scope of service.

D. Staffing

1. Routine, ongoing, Case Management Service will be conducted by Case Managers who meet minimum qualifications below:

a. Professionals having earned a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field, from an accredited college or university, or having earned a degree from an accredited School of Social Work; or,

b. A Registered Nurse with current licensure; and,

c. Training in Case Management curriculum approved by the Alabama Medicaid Agency and the Case Management service provider.

2. All Case Managers will be required to attend a Case Managers' Orientation Program provided by the Operating Agency and approved by the Alabama Medicaid Agency and attend on-going training and in-service programs deemed appropriate.

a. Initial orientation and training must be completed within the first three (3) months of employment as a Case Manager. Any exception to this requirement must be approved by the Alabama Medicaid Agency. Proof of the training must be recorded in the Case Manager's personnel file.

b. The Operating Agency will be responsible for providing a minimum of six (6) hours relevant in-service training per calendar year for Case Managers. This annual in-service training requirement may be provided during one training session or may be distributed (prorated) throughout the year based on the date of employment. Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, location and outcome of training. Topics for specific in-service training may be mandated by the Alabama Medicaid Agency. Annual in-service training must be approved by the Alabama Medicaid Agency and is in addition to the required orientation and training discussed in item 2a. Proof of training must be recorded in the personnel file. The Operating Agency shall submit proposed programs to Medicaid at least forty-five (45) days prior to the planned implementation. Any exception must be approved by the Alabama Medicaid Agency.

3. The Operating Agency shall maintain records on each Case Manager, which shall include the following:

a. Application for employment and verification of educational and licensing requirements;

b. Job description;

c. Record of health (annual tuberculin tests);

d. Record of pre-employment and annual in-service training;

e. Orientation;

f. Evaluations;

g. Supervision or peer review;

h. Copy of photo identification;

i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

j. Reference contacts;

k. Documentation of quality assurance reviews.

4. The Operating Agency must have a Quality Assurance Program for Case Management Service in place and approved by the Alabama Medicaid Agency. The Quality Assurance Program shall include Case Manager record reviews at a minimum of every sixty (60) days. Documentation of quality assurance reviews and corrective action must be maintained by the Operating Agency and will be subject to review by the Alabama Medicaid Agency.

E. Procedure for Service

1. Administrative Case Management

a. Intake and Screening

(1) Procedures for processing referrals to the E/D Waiver program and case assignment will be determined by the Operating Agency. Client freedom of choice options regarding Case Management Service shall be honored.

All enrolled waiver clients are allowed to choose case management providers and Case Managers.

b. Level of Care Determination

(1) Following referral, intake and temporary case assignment, the Case Manager makes a face-to-face visit with the client for evaluation and completion of the HCBS application. To clarify the assessment information, the Case Manager may consult with the client and/or family, and physician, with regard to medical, behavioral, functional and social information.

(2) Once the Case Manager feels that he or she has adequate information for a level of care determination, an initial Plan of Care is completed. The HCBS application is reviewed by a Registered Nurse at the Operating Agency's state office for appropriateness of waiver admission. If the RN is unable to make a level of care decision, a referral must be made to the Medicaid staff physician. Justification for level of care determination must be properly documented in the client's file.

c. Eligibility Determination

(1) Establishing and verifying a client's financial eligibility is an important function of the Case Manager. If a client is seeking waiver services, but is not currently SSI eligible and it appears that he or she may qualify for SSI, he or she should be referred to the local social security office. If a client is not SSI eligible due to income from parent(s) or spouse, a financial application (Form 204/205) must be processed to establish financial eligibility. The Case Manager should always inform the client/family of the application process. Medicaid (financial) eligibility must be verified monthly.

d. Choice of Institution or Community Care

(1) Under the provision of the E/D Waiver, applicants for waiver services or a designated responsible party will, when the applicant is found eligible for waiver services, be offered the alternative of home and community-based services or institutional services.

2. Direct Case Management

a. Plan of Care Development

(1) The Plan of Care encompasses a comprehensive review of the client's problems and strengths. Based on identified needs, mutually agreed upon goals are set. The Plan of Care development should include participation by the client and/or family/primary caregiver, and Case Manager. The Plan of Care development process provides involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

All waiver and non-waiver services provided to meet a client's needs should be included in the Plan of Care.

b. Initial Authorization of Waiver Services

The Case Manager will submit a written Service Authorization Form to the DSP Agency authorizing waiver service(s) and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

c. Service Coordination

(1) To coordinate the provision of a direct E/D Waiver service to be delivered at the client's place of residence, an initial visit should be held at the client's place of residence and should include at a minimum the Case Manager, the DSP Supervisor, the client and caregiver as applicable. It is advisable to also include the DSP Worker in the initial visit.

(2) An initial visit is required when a DSP begins to provide services to a client in the client's place of residence.

(3) If a client receives more than one direct service from a DSP, only one initial visit is required. If a client has more than one DSP, an initial visit should be conducted with each DSP.

d. Monitoring

(1) Each case will be monitored monthly through contacts and at least one face-to-face visit with the client. Special emphasis will be put on discussion of the client's current health/impairment status, appropriateness of the Plan of Care, and verification that all formal and informal providers included on the Plan of Care are delivering the amount and type of services that were committed.

(2) The amount, frequency and beginning date of service depend on the client's needs.

(3) Some cases may require monitoring more frequently than monthly. Contacts for these cases will be scheduled by prioritizing clients according to medical conditions that are unstable, clients who require extensive care, and/or clients who have limited support systems.

(4) Clients and/or responsible relatives shall be instructed to notify the Case Manager if services are not provided as planned, or if the client's condition changes. However, it is the responsibility of the Case Manager to promptly identify and implement needed changes in the Plan of Care. Providers will be contacted, as necessary, to discuss the appropriate amount of service to be delivered. The Plan of Care and service authorizations will be updated to reflect any changes in service needs.

e. Changes In Services Within Authorization Period

(1) Services may be initiated or changed at any time within an authorization period to accommodate a client's changing needs. Any change in Waiver Services necessitates a revision of the Plan of Care. The revised Plan of Care must coincide with the narrative explaining the change and a new Service Authorization Form should be submitted by the Case Manager to DSP.

(2) If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP will contact the Case Manager to discuss having these duties added.

(a) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(b) The Case Manager will approve any modification of duties to be performed by the Waiver Service Worker and re-issue the Service Authorization Form accordingly.

(c) Documentation of any change in a Plan of Care will be maintained in the client's file.

(i) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(ii) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(iii) If an individual declines waiver services or has become ineligible for services, a Service Authorization Form indicating termination is required from the Case Manager.

(iv) A new Service Authorization is required following each redetermination of eligibility, even if there are no changes to the authorized services.

f. Missed Visits and Attempted Visits

The Direct Service Provider will report missed and attempted visits to the Case Manager on Monday of each week. The DSP will notify the Case Manager promptly whenever two (2) attempted visits occur in the same week. Missed or attempted visits with clients who are at-risk will be reported to the Case Manager immediately. The Case Manager should use this information to evaluate the effectiveness of the Plan of Care and to monitor client satisfaction.

g. Re-determination

(1) A complete review of every case will be done at least annually. The review shall include completion of the same HCBS application used in the initial assessment. The client's choice of location to receive long term care and Medicaid eligibility will be verified.

h. Termination of Waivered Services

(1) Any time a client no longer requires a service, the service must be officially terminated. Advance notice and appeal rights regarding the reduction, suspension or termination of a waiver service must be granted to the client. Waiver Services may be terminated at any time during an authorization period. Termination of a service will necessitate a revision of the Plan of Care. A Service Authorization Form indicating the service is terminated must be forwarded to each DSP.

i. Case Termination and Transfer

(1) When an applicant or a current waiver client relocates to another county or Operating Agency, the case is transferred to the receiving Case Manager. The sending Case Manager prepares all necessary materials and makes initial contact with the receiving Case Manager. The receiving Case Manager is responsible for coordinating the continuation of the client's waiver services.

(2) Termination involves all activities associated with closing a waiver case when a client exits the program for specified reasons. When a client is to be terminated from the waiver, all service providers should be notified of the client's discharge immediately. At the point of termination, the Case Manager should assist as much as possible in making alternative arrangements in meeting the client's needs.

j. Documentation and Record-Keeping

(1) Adequate documentation is one of the most important tools in determining the success of the waiver program. It is vital to maintain documentation on all aspects of the waiver: from the initial data gathering process, delivery of services, complaints and grievances from recipients and providers, billing and payment records, levels of care, plans of care, Case Management narrative and cost effectiveness data. This information is used to assure that the State is operating the waiver in accordance with the approved waiver document and that waiver services are appropriate for the individuals being served.

(2) The Operating Agency shall comply with federal and state confidentiality laws and regulations in regard to client and

employee files.

(3) All records regarding the provision and supervision of Case Management must be maintained in a secure, accessible location for five (5) years after services are terminated.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The Operating Agency will ensure that the client/responsible party is informed of their right to lodge a complaint about the quality of waiver services provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

   a. Complaints which are made against a Case Manager will be investigated by the Operating Agency and documented in the client's file.

   b. The Case Manager Supervisor will contact the Case Manager by letter or telephone about any complaint against the Case Manager and any recommended corrective action.

   c. The Case Manager Supervisor will take the necessary action and document the action taken in the client's and employee's files.

   d. All other complaints to be investigated will be referred to the Case Manager who will take appropriate action.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The Operating Agency will designate an individual to serve as the waiver coordinator who will employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not

have to be a full time position; however, the designated waiver coordinator must have the authority and responsibility for the direction of the Operating Agency. The Operating Agency shall notify in writing the Alabama Medicaid Agency within three (3) working days of a change in the waiver coordinator, address, phone number or an extended absence of the waiver coordinator.

2. The Operating Agency will maintain an organizational chart indicating the lines of authority and responsibility and make it available to the Alabama Medicaid Agency upon request.

3. Administrative and supervisory functions shall **not** be delegated to another agency or organization.

4. The Operating Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery. All policies and procedures must be approved by the Alabama Medicaid Agency.

SCOPE OF SERVICE
FOR
HOMEMAKER SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Homemaker Service provides assistance with general household activities such as meal preparation and routine housecleaning and tasks, such as, changing bed linens, doing laundry, dusting, vacuuming, mopping, sweeping, cleaning kitchen appliances and counters, removing trash, cleaning bathrooms, and washing dishes. This service may also include assistance with such activities as obtaining groceries and prescription medications, paying bills, and writing and mailing.

Homemaker Services is not an entitlement. It is based on the needs of individual client as reflected in the Plan of Care.

B. Objective

The objective of Homemaker Services (HM) are to preserve a safe and sanitary home environment, assist clients with home care management duties, to supplement and not replace care provided to clients, and to provide needed observation of clients participating in the Elderly/Disabled waiver.

C. Description of Service to be Provided

1. The unit of service is one (1) hour of direct Homemaker Service provided in the client's residence (except when shopping, laundry services, etc. must be done off-site). The amount of time authorized does not include the Homemaker's transportation time to or from the client's residence, or the Homemaker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's needs as set forth in the Plan of Care.

   Medicaid will not reimburse for activities performed which are not within the scope of services.

3. No payment will be made for services that are not listed on the Plan of Care and the Service Authorization Form.

4. Homemaker Services duties include, but are not limited to, the following:

   a. Meal or snack preparation, meal serving, cleaning up afterwards;

   b. General housekeeping includes cleaning (such as sweeping, vacuuming, mopping, dusting, taking out trash, changing bed linens, defrosting and cleaning the refrigerator, cleaning the stove or oven, cleaning bathrooms); laundry (washing clothes and linen, ironing, minor mending); and, other activities as needed to maintain the client in a safe and sanitary environment;

   c. Essential shopping for food and other essential household or personal supplies which may be purchased during the same trip, and picking up prescribed medication;

   d. Assistance with paying bills which includes opening bills, writing checks but not signing them and delivering payments to designated recipients on behalf of the client;

   e. Assistance with communication which includes placing phone within client's reach and physically assisting client with use of the phone, orientation to daily events, paying bills, and writing letters;

   f. Observing and reporting on client's condition;

   g. The homemaker is not allowed to transport the client by vehicle in the performance of their task.

   h. Reminding clients to take medications

Note: Under no circumstances should any type of skilled medical or nursing service be performed by a Homemaker.

5. The Direct Service Provider (DSP) is not responsible for providing funds, supplies, or groceries to perform Homemaker Services.

D. Staffing

The DSP must provide all of the following staff positions through employment and/or subcontractual arrangements.

1. All Homemaker Supervisors will have the following qualifications:
   a. High school diploma or equivalent;
   b. Be able to evaluate homemakers in terms of their ability to perform assigned duties and to relate to the client;

c. Have the ability to coordinate or provide orientation and in-service training to Homemaker Workers on either an individual basis or in a group setting;
d. Submit to a program for the testing, prevention, and control of tuberculosis annually;
e. Must have references which will be verified thoroughly and documented in the DSP personnel file. (References can include criminal background checks, previous employers, and/or aide register);
f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of HM service;
g. Have the ability to evaluate the Homemaker Worker (HM Worker) in terms of his/her ability to carry out assigned duties and to relate to the client;
h. Possess a valid, picture identification.

2. All individuals providing Homemaker Service must meet the following qualifications:
   a. Be able to read and write;
   b. Submit to a program for the testing, prevention, and control of tuberculosis annually;
   c. Have references which will be verified thoroughly and documented in the DSP personnel file. (References can include criminal background checks, previous employers, and/or aide register);
   d. Be able to work independently on an established schedule; and,
   e. Possess a valid, picture identification;.
   f. Be able to follow the Plan of Care with minimal supervision.
   g. Complete a probationary period determined by the employer with continued employment contingent on completion of a Homemaker in-service training program.
3. Minimum Training Requirements for Homemakers:

   The Homemaker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Homemaker training program must be approved by the Operating Agency the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

   The annual in-service training is in addition to the training required prior to the provision of care.

All Homemakers must have at least six (6) hours, in-service training annually from the following areas:

a. Maintaining a safe and clean environment;

b. Providing care including individual safety, laundry, serve and prepare meals, and household management;

c. First aid in emergency situations;

d. Fire and safety measures;

e. Client rights;

f. Record keeping; such as,

- A service log signed by the client or family member/ responsible person and Homemaker Worker to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the Homemaker Worker Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.

g. Communication skills;

h. Basic infection control/Universal Standards;

i. Other areas of training as appropriate or as mandated by Medicaid, or the Operating Agency.

4. The DSP will be responsible for providing a minimum of six (6) hours of relevant in-service training per calendar year for each Homemaker Worker. In-service training is in addition to Homemaker Worker orientation training. For Homemaker Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a Homemaker Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

6. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

7. In-service training may entail demonstration of maintaining a safe and clean environment for the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency and the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Homemaker Workers each calendar year.

9. The DSP Agency shall maintain records on each employee, which shall include the following:

    a. Application for employment;

    b. Job description;

    c. Record of health (annual tuberculin tests);

    d. Record of pre-employment and in-service training;

    e. Orientation;

    f. Evaluations;

    g. Supervisory visits;

    h. Copy of photo identification;

    i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

    j. Reference contacts;

    k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Homemaker Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate Homemaker Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.
   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized.

3. The DSP Agency may recommend to the Case Manager any changes in the hours, times, or specified duties requested. The Case Manager will review a client's Plan of Care within one (1) working day of the DSP's request to modify the Plan of Care. A change in the Service Authorization Form will be submitted to the DSP Agency if the Case Manager concurs with the request.

4. Homemakers will maintain a separate service log to document their delivery of services.

   a. The Homemaker shall complete a service log daily. The service log will reflect the types of services provided, the number of hours of service, and the times of service.

   b. The service log must be signed upon each visit by the client, or family member/responsible party and the Homemaker Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Homemaker must document the reason the log was not signed by the client or family member/responsible party.

   c. The service log will be reviewed and signed by the Homemaker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

   d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number

exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone. These electronic records may be utilized in place of client signatures.

5. Provision of Service Authorized:

   a. Homemaker Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.

   b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide.

6. Monitoring of Service

   Homemaker Service must be provided under the supervision of the individual who meets the qualifications in D.1. and will:

   a. Make the initial visit to the client's residence prior to the start of Homemaker Service for the purpose of reviewing the Plan of Care and discuss with the client the provisions and supervision of the service.

      The initial visit should be held at the client’s place of residence and should include the Case Manager, the Homemaker Supervisor, the client and caregiver if feasible. It is advisable to also include the Homemaker Worker in the initial visit.

   b. Be immediately accessible by phone during the time Homemaker Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

   c. Provide and document supervision of, training for, and evaluation of Homemaker Workers according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of the Homemaker Worker at a minimum of every ninety (90) days for each client. Supervisory visits must be documented in the individual client record and a copy placed in the worker's personnel file. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Homemaker Worker. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Homemaker Service. Documentation regarding this action should be in the DSP client record.

e. The DSP must complete the ninety (90) day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (l0) calendar days after the ninety (90) day supervisory review.

f. Assist Homemaker Workers as necessary as they provide individual Homemaker Service as outlined in the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

g. The Homemaker Supervisor must provide direct supervision of each Homemaker Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Homemaker Worker's personnel record.

(1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The Homemaker Supervisor will provide and document the supervision, training, and evaluation of Homemaker Workers according to the requirements in the approved Waiver Document.

7. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Homemaker Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

b. Clients who are designated by the Case Manager as being at-risk should be given first priority when Homemaker Service visits must be temporarily prioritized and/or reduced by the DSP.

(1) If the Supervisor sends a substitute, the substitute will complete and sign the daily log after finishing duties. If a substitute Homemaker Worker was offered to the client/caregiver, but refused, this should be documented in the DSP client record on the **"Weekly Missed/Attempted Visit Report."**

(2) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Homemaker Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/ Attempted Visit Report"** form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may **not** bill for missed visits**.**

c. Attempted Visits

(1) An attempted visit occurs when the Homemaker Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Supervisor will contact the client or family member to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager promptly whenever two consecutive attempted visits occur during the same week.

8. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs:

(2) Client does not appear to need Homemaker Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Homemaker Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the HMW and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any change in the Plan of Care or Service Authorization Form will be maintained in the client's file.

(a) If the total number of hours or types of services are changed, a new Service Authorization Form is required from the Case Manager.

(b) If an individual declines Homemaker Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

9. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

b. The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Homemaker visits for the client;

(3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Homemaker Worker;

(4) All service logs;

(a) The service log must be reviewed and initialed by the Homemaker Supervisor at least once every two (2) weeks.

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 90 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

c. The DSP will retain a client's file for at least five (5) years after services are terminated.

d. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Homemaker Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against HMW will be investigated by the DSP Agency and documented in the client's file.

b. All complaints which are to be investigated will be referred to the HMW Supervisor who will take appropriate action.

c. The HMW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.

d. The HMW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and

documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency and the Alabama Medicaid Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. Administrative and supervisory functions shall **not** be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Homemaker Service must meet all provider qualifications prior to rendering the Homemaker Service.

SCOPE OF SERVICE
FOR
RESPITE CARE SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Respite Care is provided to individuals unable to care for themselves and is furnished on a short-term basis because of the absence of, or need for relief of those persons normally providing the care.

Skilled or Unskilled Respite is provided for the benefit of the client and to meet client needs in the absence of the primary caregiver(s) rather than to meet the needs of others in the client's household.

Respite Care is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems. This service will provide temporary, short term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence of the primary caregiver.

C. Description of Service to be Provided

1. The unit of service is one (l) hour of direct Respite Care provided in the client's residence. The amount of time does not include the Respite Care Worker's (RCW) transportation time to or from the client's residence or the Respite Care Worker's break or mealtime.

2. The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year (October 1-

September 30) in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. As implied in the definition, Respite Care is for the relief of the family member or primary caregiver; therefore, there must be a primary caregiver identified for each client that uses the Respite Care Service. The primary caregiver does not have to reside in the residence; however, there must be sufficient documentation to establish that the primary caregiver to be relieved furnishes substantial care of the client.

4. This service must not be used to provide continuous care while the primary caregiver is working or attending school.

5. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.

6. The type of in-home respite (skilled or unskilled) provided to each client will be dependent upon the individual client's needs as established by the Case Manager and set forth in the client's Plan of Care.

    a. Skilled Respite:

        (1) Skilled Respite Service will provide skilled medical or nursing observation and services and will be performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act.

            (a) Orders from the client's physician(s) are required annually.

            (b) It is the responsibility of the Skilled Respite Provider to obtain such physician orders for the skilled nursing services needed by the client.

        (2) In addition to providing supervision to the client, Skilled Respite may include, but is not limited to, the following activities:

(a) Assistance with activities of daily living (ADLs), such as,

- Bathing, personal hygiene and grooming
- Dressing
- Toileting or activities to maintain continence
- Preparing and serving meals or snacks and providing assistance with eating
- Transferring
- Ambulation

(b) Home support that is essential to the health and welfare of the recipient, such as,

- Cleaning
- Laundry
- Assistance with communication
- Home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the Case Manager for follow-up.

(c) Skilled nursing services as ordered by the client's physician, including administering medications.

(d) Skilled medical observation and monitoring of the client's physical, mental or emotional condition and the reporting of any changes.

(e) Orienting the client to daily events.

b. Unskilled Respite:

(1) Unskilled Respite Services will provide and/or assist with activities of daily living and observations. Unskilled Respite will be performed by a Personal Care or Homemaker Worker.

(2) In addition to providing supervision to the client, Unskilled Respite may include, but is not limited to, the following activities:

(a) Provision of Personal Care or Homemaker Service which would ordinarily be performed by the primary caregiver(s) based on the individual needs of the client. (See Scope of Service for Personal Care and Homemaker Service.)

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

1. Skilled Respite Supervisors must meet the following qualifications and requirements:

a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (Reference may include criminal background checks, previous employers, and/or aide register.)

b. Be a Registered Nurse (RN) who is currently licensed by the Alabama StateBoard of Nursing to practice nursing.

c. Have at least two (2) years experience as a Registered Nurse in public health, hospital, home health, or long term care nursing.

d. Have the ability to evaluate the Skilled Respite Worker (SR Worker) in terms of his or her ability to carry out assigned duties and his or her ability to relate to the client.

e. Have the ability to assume responsibility for in-service training for RCWs by individual instruction, group meetings or workshops.

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Respite Care Service.

g. Submit to a program for the testing, prevention, and control of tuberculosis annually.

h. Possess a valid, picture identification.

Unskilled Respite Supervisors must meet the same qualifications as a Personal Care Supervisor or Homemaker Supervisor depending on the level of care. (See Scope of Service for Personal Care and Homemaker Service.)

2. Skilled Respite Worker - A Licensed Practical Nurse (LPN) or Registered Nurse (RN) who meets the following requirements:

   a. Be currently licensed by the State of Alabama to practice nursing.

   b. Have at least two years experience in public health, hospital, or long term care nursing.

   c. Submit to a program for testing, prevention, and control of tuberculosis, annually.

   d. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

   e. Possess a valid, picture identification.

   Minimum Training Requirements for Skilled Respite Care Workers (LPN or RN):

   The Direct Service Provider (DSP) must assure Medicaid and the Operating Agency (OA) that the nurse has adequate experience and expertise to perform the skilled services and the care required by the client.

   Provide validation of CEUs for licensure.

3. Unskilled Respite Worker - Respite Care Workers who meet the following qualifications and requirements:

   a. Unskilled Respite Workers must meet the same qualifications as a Personal Care Worker and Homemaker Worker dependent upon of level of care. (See Scope of Service for Personal Care and Homemaker Service.)

   Minimum Training Requirements for Unskilled Respite Care Workers:

   Unskilled Respite Workers must meet the same orientation and in-service training requirements as a Personal Care Worker and Homemaker Worker dependent upon the level of care. (See Scope of Service for Personal Care and Homemaker Service.)

4. The DSP Agency shall maintain records on each employee which shall include the following:

   a. Application for employment;

   b. Job description;

   c. Record of health (annual tuberculin tests);

   d. Record of pre-employment and annual in-service training;

      (1) For Skilled Respite Supervisors and Skilled Respite Workers validation of required CEUs for licensure will be accepted for in-service.

   e. Orientation;

   f. Evaluations;

   g. Supervisory visits;

   h. Copy of photo identification;

   i. Records of all complaints/incidents lodged by the client/family/responsible party and action taken;

   j. Reference contacts;

   k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Respite Care designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs. This documentation will be maintained in the client's file.

2. The DSP Agency will initiate Respite Care within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form.

c. No payment will be made for services unless authorized and listed on the Plan of Care.

d. The DSP will retain a client's file for at least five (5) years after services are terminated.

3. Provision of Service authorized:

a. Respite Care cannot be provided at the same time other authorized waiver services are being provided with the exception of Case Management.

b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide.

4. Respite Care Worker will maintain a separate service log for each client to document their delivery of services.

a. The Respite Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

b. The service log must be signed upon each visit by the client, or family member/responsible party. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Respite Care Worker must document the reason the log was not signed by the client or family member/responsible party.

c. The Skilled Respite Worker must fully document the skilled nursing services that were authorized by the client's physician and performed for the client during each visit in which Skilled Respite was provided.

d. The service logs for Unskilled Respite and the documentation forms for Skilled Respite will be reviewed and signed by the Unskilled or Skilled Respite Supervisor respectively at least once every two (2) weeks. Daily service logs and documentation forms will be retained in the client's file.

e. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

f. The DSP Supervisor should notify the Case Manager in writing regarding any report or indication from the DSP Worker regarding a significant change in the client's physical, mental or emotional health. The DSP Supervisor should document such action in the DSP client file.

5. Monitoring of Service:

Unskilled Respite Care must be provided under the supervision of the Registered Nurse or Licensed Practical Nurse who meets the requirements of D.1.a.-d. or the Homemaker Worker Supervisor and will:

a. Make the initial visit to the client's residence prior to the start of Respite Care for the purpose of reviewing the Plan of Care and providing the client written information regarding rights and responsibilities and how to register complaints.

b. Be immediately accessible by phone. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours if the position becomes vacant.

c. Provide and document supervision of, training for, and evaluation of Unskilled Respite Care Workers according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of the Unskilled Respite Care Worker at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the employee's file and reported to the Case Manager. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the Unskilled Respite Care Worker.

e. Assist Unskilled Respite Care Workers as necessary as they provide individual Respite Service as outlined by the Plan of Care. Any supervision/assistance given must be documented in the individual client's record.

6. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

2) The DSP shall have a written policy assuring that when a Respite Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

(a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Respite Care Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided as authorized, the Case Manager must be notified by telephone immediately. All missed visits must be reported in writing on the "**Weekly Missed/Attempted Visit Report**" form to the Case Manager on Monday of each week.

(5) The DSP may **not** bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Respite Care Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager promptly whenever an attempted visit occurs.

7. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Respite Care;

(3) Client dies or moves out of the service area;

(4) Client indicates Respite Care Service is not wanted; and,
(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically and financially ineligible for waiver services.

The Case Manager must verify Medicaid eligibility on a monthly basis.

c. If the DSP identifies additional duties that would be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.
(2) The Case Manager will approve any modification of duties to be performed by the Respite Care and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Respite Care or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system which documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the Operating Agencies, or other agencies contractually required to review information upon request. The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Respite Care visits for the client;

(3) All service logs;

(a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(4) Records of all missed or attempted visits;

(5) Records of all complaints lodged by clients or family members/responsible parties and any actions taken;

(6) Evaluations from all 60 day on-site supervisory visits to the client;

(7) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(8) The name of the primary caregiver.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Case Manager has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Respite Care Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against Respite Care Workers will be investigated by the DSP and documented in the client's file.

b. All complaints to be investigated will be referred to the Respite Care Worker Supervisor who will take appropriate action.

c. The Respite Care Worker Supervisor will take any action necessary and document the action taken in the client's and employee's files.

d. The Respite Care Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

l. The DSP Agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the

direction of the DSP Agency. The DSP Agency shall notify the Operating Agency and the Alabama Medicaid Agency within (3) working days of a change in the agency administrator, address, or phone number.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Respite Care must meet all provider qualifications prior to rendering the Respite Care Service.

SCOPE OF SERVICE
FOR
ADULT DAY HEALTH SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Adult Day Health (ADH) is a service that provides Elderly and Disabled Waiver (EDW) clients with a variety of health, social, recreational, and support activities in a supervised group setting for four or more hours per day on a regular basis.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of Adult Day Health Service. The cost of this transportation is included in the rate paid to providers of Adult Day Health Service.

Adult Day Health is not an entitlement. It is based on the needs of the individual client.

B. Objective

The objective of Adult Day Health is to provide a continuing organized program of rehabilitative, therapeutic and supportive health and social services and activities to the Elderly and Disabled Waiver clients who are functionally impaired and who, due to the severity of their functional impairment, are not capable of living in the community independently.

C. Description of Adult Day Health Service to be Provided

The unit of service will be a client day of Adult Day Health Service consisting of four (4) or more hours at the center. The four (4) hour minimum for a client day does not include transportation time. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form.

Medicaid will not reimburse for activities performed which are not within the scope of service.

Adult Day Health Service is provided within a maintenance model of care, which provides services that include the following health and social activities, needed to ensure optimal functioning of the client.

1. Observe the status of the individual health that includes support in carrying out physician orders as needed; monitoring of vital signs as needed; observing the

functional level of the client and noting any changes in the physical condition of each individual; supervising medication and observing for possible reaction; teaching positive health measures and encouraging self-care; appropriately reporting to the caregiver and case manager any changes in the client's condition.

2. According to the Alabama Board of Nursing medications can be administered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing. The medication must be filled by a pharmacy with physician instructions written on the label. The written instructions on the container are considered a physician order. However, the nurse has an additional obligation to keep a record of all medications given to a client in the client's file. This policy is applicable, if a nurse is on staff at the facility. Medications cannot be administered by any other staff member at the ADH center. However, the other staff member can remind a client to take medication when necessary.

3. Observe and assist the client to maintain good personal hygiene on a daily basis.

4. Provide planned therapeutic activities on a daily basis to stimulate the client's mental and physical activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural program, and games, etc.

5. Provides a variety of opportunities for group socialization.

6. Observe and assist the client with meal and eating.

7. Develop a plan to address medical emergencies, fire, and natural disaster.

8. Assist in the development of self-care, personal hygiene, and social support services.

9. Provide nourishment appropriate to the number of hours he or she attends the Adult Day Health center, but not equal to a full nutritional regime (3 meals per day). Specific diet requirements should be encouraged.

10. No other waiver service, except Case Management, may be provided during the time the client is receiving Adult Day Health Service.

Note: Under no circumstances should the unlicensed Adult Day Health Workers perform any type of skilled medical or nursing service.

D. Staffing

The DSP must provide all of the following staff positions through employment or sub-contractual arrangements.

1. Director of Adult Day Health Centers

All Adult Day Health Center Directors must meet the following requirements:

a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register);

b. Have sufficient education (high school diploma or equivalent) and language ability to communicate effectively, understand written instructions and write basic reports;

c. Have the ability to evaluate Adult Day Health employees in terms of their ability to perform assigned duties and communicate with the clients;

d. Have the ability to assume responsibility for orientation and in-service training for Adult Day Health Workers by individual instructions, group meetings, or workshops;

e. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Adult Day Health Service;

f. Submit to a program for the testing, prevention, and control of tuberculosis annually;

g. Possess a valid, picture identification.

2. Adult Day Health Workers

Staff, volunteer and paid employees must meet the following requirements:

a. Be able to follow the Plan of Care with minimal supervision;

b. Be able to read and write;

c. Submit to a program for the testing, prevention, and control of tuberculosis annually;

d. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register);

e. Have a valid Alabama driver's license if transporting Adult Day Health clients;

f. Possess a valid, picture identification.

3. Training

The Adult Day Health training program should stress the physical, emotional and developmental needs of the population services, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing and/or conducting the training. The Adult Day Health training program must be approved by the Operating Agency and the Alabama Medicaid Agency. Proof of the training must be recorded in the Adult Day Health Worker personnel file.

Individual records will be maintained on each Adult Day Health Worker to document that each member of the staff has met the requirements below.

All Adult Day Health Workers must have at least six (6) hours in-service training annually. Training requirements must include the following areas:

a. Behavioral interventions, acceptance, and accommodation;

b. Providing care and supervision including individual safety and non-medical care;

c. First aid in emergency situations;

d. Documenting client's participation;

e. Fire and safety measures;

f. Confidentiality;

g. Client rights;

h. Needs of the elderly and disabled population;

i. Basic infection control/Universal Standards;

j. Communication skills;

k. Other areas of training as appropriate or as mandated by Medicaid and the Operating Agencies.

Documentation of the training provided shall include topic, name and title of trainer, objective of the training, date of the training, outline of content, length of training, list of trainees and location.

Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit proposed program(s) to the Operating Agency and the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation. The in-service training is in addition to the required training prior to delivery of Adult Day Health Service.

The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service training for all Adult Day Health Workers each calendar year.

The Adult Day Health center must maintain records on each employee, which must include the following:

(1) Application for employment;

(2) Job description;

(3) Record of health (annual tuberculin tests);

(4) Record of pre-employment and in-service training;

(5) Orientation;

(6) Evaluations;

(7) Reference contacts;

(8) Records of all complaints/incidents lodged by the client/family and action taken.

(9) Other forms as required by state and federal law, including agreements regarding confidentiality.

4. Nursing Staff

A Registered Nurse(s) or Licensed Practical Nurse(s) who meets the following requirements:

a. Currently licensed by the Alabama State Board of Nursing.

b. At least two (2) years experience as a Registered Nurse or Licensed Practical Nurse in public health, hospital or long-term care nursing.

c. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

d. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

e. Possess a valid, picture identification.

E. Procedure of Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the Adult Day Health center authorizing Adult Day Health Service designating the units, frequency, beginning date of service, and types of activities in accordance with the clients needs.

2. The Adult Day Health Provider will initiate Adult Day Health Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

b. The Adult Day Health Provider will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Missed Visits

a. A missed visit occurs when the client is scheduled but does not attend.

b. All client absences for the week must be reported in writing to the Case Manager on Monday of the new week.

4. Changes in Services

a. The Adult Day Health Provider will notify the Case Manager within one (1) working day of a change in the client's condition, or if Plan of Care no longer meets the client's needs or the client no longer appears to need Adult Day Health Service.

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Adult Day Health Service.

(3) Client dies or moves out of the service area;

(4) Client indicates Adult Day Health Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the Adult Day Health Worker and re-issue the Service Authorization Form accordingly, if he/she concurs with the request.

(3) Documentation of any change in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Adult Day Health Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

5. Documentation Record-Keeping

a. The Adult Day Health Provider will maintain a record-keeping system, which establishes a client profile based on the Service Authorization Form.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms;

(3) Documentation of all care and services provided;

(4) Records of all complaints lodged by clients or family members/responsible parties and any action taken;

(5) All service logs;

(6) Any notification to Case Manager.

(7) Daily attendance records must be kept in each individual client file. The attendance record should be initialed daily and signed weekly by the client. In the event the client is not able to sign and family member or responsible party is not present to sign, the Adult Day Health center must document on the attendance record the reason the attendance record was not signed in the client file. The attendance record must be reviewed and initialed by the Adult Day Health Center Director at least every two (2) weeks.

The Adult Day Health Provider should notify the Case Manager in writing regarding any report or indication from the Adult Day Health Worker regarding a significant change in the client's physical, mental or emotional health. The Adult Day Health Supervisor should document such action in the DSP client file.

6. The Adult Day Health Provider must submit to the Case Manager, every sixty (60) days a brief summary of the client's condition, an evaluation of the effectiveness of the service as it relates to the Plan of Care, and suggestions relative to the client's needs. The activities the client participates in should be included in the brief summary.

7. The Adult Day Health Provider shall comply with federal and state confidentiality laws and regulations in regard to client and personnel file.

8. The Case Manager will request Adult Day Health Service by authorizing the amount, beginning dates of service, and frequency of service for clients in accordance with the client's Plan of Care which will be developed in consultation with the client.

9. The Case Manager will notify the Adult Day Health Provider immediately if a client becomes medically or financially ineligible for Adult Day Health Service.

10. The number of days a client attends each week is dependent upon the individual client's needs as set forth in the Plan of Care established by the case manager.

11. No payment will be made for services not documented on the Plan of Care and the Service Authorization Form.

12. Medicaid will not reimburse for activities performed which are not within the scope of services.

F. Conditions of Participation

1. The Adult Day Health Provider must maintain a current Adult Day Health approval issued from the Alabama Medicaid Agency. (The Alabama Medicaid Agency issues approval for only those Adult Day Health centers that participate in the Elderly and Disabled Waiver program.) Approval depends upon compliance with the Adult Day Care Standards in Appendix B.2.a and the Adult Day Health Service requirements in the approved Elderly and Disabled Waiver document. The approval will be issued by the Alabama Medicaid Agency after an on-site visit by the Quality Assurance Unit. The Adult Day Health center will be issued an approval for the facility to participate in the Elderly and Disabled Waiver program for a period of no more than one (1) year if all requirements are met. Requirements for approval are as follows:

   a. The Adult Day Health center must meet the standards in Appendix B.2.a;

   b. The Adult Day Health center must meet the requirements in the approved waiver document;

   c. Services must be delivered consistent with the Plan of Care; and,

   d. The clients needs must be met.

   None of these requirements should be deviated from.

2. The Adult Day Health Provider will incorporate in the procedures for operation of the center adequate safeguards to protect the health and safety of the clients in the event of a medical or other emergency.

3. The Adult Day Health Provider must maintain a current (within past l2 months) fire inspection.

4. The Adult Day Health Provider must maintain a current (within past l2 months) health inspection if food is prepared and an approval from the Health Department (within l2 months) if receiving catered food.

5. The Adult Day Health Provider must maintain adequate staff for the number of clients served in the center.

   a. One Adult Day Health Worker plus the director for 1-10 clients.

   b. Two Adult Day Health Workers plus the director for 11-25 clients.

c. Three Adult Day Health Workers plus the director for 26-35 clients.

d. Four Adult Day Health Workers plus the director for 36-43 clients.

Add one Adult Day Health Worker for each additional 8 clients.

6. The Adult Day Health Provider must have at least two staff members certified in CPR and First Aid.

7. The Adult Day Health Provider must have one person trained to act on behalf of the Adult Day Health Director in his or her absence.

8. The Adult Day Health Provider must have a registered nurse (RN) or license practical nurse (LPN) available two hours per week or eight hours per month for consultation. Monthly health screening of all clients is part of the consultation.

G. Rights, Responsibilities, and Service Complaints

The Operating Agency has the responsibility of ensuring that the Adult Day Health Provider has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Adult Day Health Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

1. Complaints that are made against Adult Day Health Workers will be investigated by the Adult Day Health Provider and documented in the client's file.

2. All complaints that are to be investigated will be referred to the Adult Day Health Director who will take appropriate action.

3. The Adult Day Health Director will take any action necessary and document the action taken in the client and employee's files.

4. The Adult Day Health Director will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

5. The Adult Day Health Provider must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints

and documentation showing that they have complied with the requirements of this section.

H. Administrative Requirements

In addition to all conditions and requirements contained elsewhere in this Scope of Services as well as in the Adult Day Care standards and the contract, the Adult Day Health Provider shall be required to adhere to the following stipulations:

1. The Adult Day Health Provider shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Adult Day Health Center. The Adult Day Health Provider shall notify the Operating Agency within three (3) working days in the event of a change in the agency administrator, address, or phone number.

2. The agency will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands-on" client care level staff shall be set forth in writing. This information shall be readily accessible to all staff and shall include an organizational chart. A copy of this information shall be forwarded to the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Adult Day Health Provider and to the Operating Agency.

3. The Adult Day Health Provider shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Adult Day Health center. A list of the members of the governing body will be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The Adult Day Health Provider must maintain an annual operating budget, which will be made available to the Operating Agency or the Alabama Medicaid Agency upon request.

7. The Adult Day Health Provider will acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff including board members, from liability incurred while acting on behalf of the Adult Day Health Center. Upon request, the Adult Day Health Provider will furnish a copy of the insurance policy to the Operating Agency and the Alabama Medicaid Agency.

SCOPE OF SERVICE
FOR
COMPANION SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult. Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services. The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual. Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely diversional in nature. The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

Companion Service is not an entitlement. It is provided based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of Companion Service is to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the Elderly and Disabled Waiver.

C. Description of Service to be Provided

1. The unit of service will be one (1) hour of direct Companion Service provided to the client. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The maximum number of units that can be authorized may not exceed four (4) hours daily. The amount of time authorized does not include the Companion Worker's transportation time to or from the client's home, or the Companion Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care which is established by the Case Manager and subject to approval by the Medicaid Agency.

Medicaid will not reimburse for activities performed which are not within the scope of services defined.

3. Companion Service includes:

a. Supervision/observation of daily living activities, such as,

(1) Reminding client to bathe and take care of personal grooming and hygiene;

(2) Reminding client to take medication;

(3) Observation/supervision of snack, meal planning and preparation, and/or eating;

(4) Toileting or maintaining continence.

b. Accompanying the client to necessary medical appointments, grocery shopping, and obtaining prescription medications. The Companion Worker is not allowed to transport clients, only to accompany them.

c. Supervision/assistance with laundry.

d. Performance of housekeeping duties that are essential to the care of the client.

e. Assist with communication.

f. Reporting observed changes in the client's physical, mental or emotional condition.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

1. Companion Worker Supervisors' Qualifications

All Companion Worker Supervisors will have the following qualifications:

a. High school diploma or equivalent;

b. Be able to evaluate Companion Worker in terms of their ability to perform assigned duties and communicate with the individuals;

c. Be able to assume responsibility for in-service training for Companion Workers by individual instructions, group meetings, or workshops;

d. Submit to programs for the testing, prevention, and control of tuberculosis annually;

e. Have reference which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background employers, and/or aide register);

f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of Companion Service;

g. Possess a valid, picture identification.

2. All Companions Workers must meet the following qualifications:

a. Be able to read and write;

b. Submit to programs for the testing, prevention, and control of tuberculosis annually;

c. Have references which will be verified thoroughly and documented in the Direct Service Provider's personnel file (references may include criminal background checks, previous employer and/or aide register);

d. Possess a valid, picture identification;

e. Be able to follow the Plan of Care with minimal supervision unless there is a change in the client's condition.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of the in-service training program.

3. Minimum Training Requirements for Companion Worker

The Companion Worker training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Companion Worker training program must be approved by the Operating Agency and the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

The Companion Worker must successfully complete orientation training in areas specified below prior to providing Companion Services or have documentation of personal, volunteer, or paid experience in the care of adults, families, and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing.

a. Meal planning and preparation;

b. Laundry/shopping;

c. Provision of care and supervision including individual safety;

d. First aid in emergency situations;

e. Documentation of services provided per written instructions;

f. Basic infection Control/Universal Standards; and,

g. Fire and safety measures;

h. Assist clients with medications;

i. Communication skills;

j. Client rights;

k. Other areas of training as appropriate or as mandated by Medicaid and/or he Operating Agency.

4. The annual in-service training will be provided by the DSP and is in addition to the training required prior to job placement.

5. All Companion Workers must have at least six (6) hours in-service training annually. For Companion Workers hired during the calendar year, this

in-service requirement may be prorated based on date of employment as a Companion Worker.

6. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

7. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

8. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training. The DSP shall submit the proposed program(s) to the Operating Agency and the Alabama Medicaid Agency at least forty-five (45) days prior to the planned implementation.

9. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the six (6) hours required in-service for all Companion Workers each calendar year.

10. The DSP Agency shall maintain records on each employee which shall include the following:

a. Application for employment;

b. Job description;

c. Record of health (annual tuberculin tests);

d. Record of pre-employment and in-service training;

e. Orientation;

f. Evaluations;

g. Supervisory visits;
h. Copy of photo identification;

i. Reference contacts;

j. Other forms as required by State and Federal law, including agreements regarding confidentiality.

E. Procedure for Service

1. The Case Manager will submit a Service Authorization Form and a copy of the Plan of Care to the DSP Agency, authorizing Companion Service and designating the units, frequency, beginning date of service, and types of duties in accordance with the individual client's needs as set forth in the Plan of Care.

2. The DSP Agency will initiate Companion Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form:

b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

a. Companion Service cannot be provided at the same time as other authorized waiver services are being provided, except for case management.

b. Services provided by relatives or friends may be covered only if relatives or friends meet the qualifications as providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide.

c. The Companion Worker is not allowed to provide transportation when he/she is accompanying a client.

d. Companion service is available only to those clients who reside alone.

4. Companion Workers will maintain a separate service log for each client to document their delivery of services.

a. The Companion Worker shall complete a service log that will reflect the types of services provided the number of hours of service, and the date and time of the service.

b. The service log must be signed upon each visit by the client, or family member/responsible party and the Companion Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Companion Worker must document the reason the log was not signed by the client or family member/responsible party.

c. The service log will be reviewed and signed by the Companion Worker Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

d. Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

5. Monitoring of Service

a. The Companion Worker Supervisor will visit the home of clients to monitor services.

(1) The Companion Worker Supervisor will make the initial visit to the client's residence prior to the start of Companion Service for the purpose of reviewing the Plan of Care and discuss with the client the provisions and supervision of the service.

The initial visit should be held at the client's place of residence and should include the Case Manager, the Companion Supervisor, the client and caregiver if feasible. It is advisable to also include the Companion Worker in the initial visit.

(2) The Companion Worker Supervisor will provide on-site supervision at the client's place of residence at a minimum

of every 90 days for each client. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the Companion Worker. Supervisory visits must be documented in the individual client record and a copy placed in the individual's personnel file.

In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Companion Service. Documentation regarding this action should be in the DSP client file.

(3) Each Companion Worker supervisory visit will be documented in the client's file. The Companion Worker Supervisor's report of the on-site visits will include, at a minimum:

(a) Documentation that services is being delivered consistent with the Plan of Care;

(b) Documentation that the client's needs are being met;

(c) Reference to any complaints which the client or family member/responsible party have lodged and action taken;

(d) A brief statement regarding any changes in the client's Companion Service needs.

(e) The Companion Service Supervisor will provide Assistance to Companion Worker as necessary.

(f) Companion Worker Supervisor must be immediately accessible by phone during the time Companion Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant, the Operating Agency and the Alabama Medicaid Agency must be notified in

writing within 24 hours if the position becomes vacant.

(g) The Companion Worker Supervisor must provide direct supervision of each Companion Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the Companion Worker's personnel record.

(i) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

(h) The Companion Worker Supervisor will provide and document the supervision, training, and evaluation of Companion Workers according to the requirements in the approved Waiver Document.

6. Missed Visits, and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Companion Worker is unavailable, the Companion Worker Supervisor will assess the need for services and makes arrangements for a substitute to provide services as necessary.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Companion Service visits must be temporarily prioritized and/or reduced by the DSP.

(a) If the Companion Worker Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Companion Worker Supervisor does not send a substitute, the Companion Worker Supervisor will

contact the client and inform them of the unavailability of the Companion Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the "**Weekly Missed/ Attempted Visit Report**" form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may **not** bill for missed visits.

b. Attempted Visits

(1) An attempted visit occurs when the Companion Worker arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Companion Worker Supervisor will contact the client to determine the reason why the client was not present or why services were refused, and document in the client's file.

(c) The DSP will notify the Case Manager promptly whenever an attempted visit occurs.

7. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and that the Plan of Care no longer meets the client's needs;

(2) Client does not appear to need Companion Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Companion Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP within one (1) working day if a client becomes ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the Companion and re-issue the Service Authorization Form accordingly.

(3) Documentation of any changes in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines Companion Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

8. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available upon request to Medicaid, the administering agencies, or other agencies contractually required to review information.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Companion visits for the client;

(3) Documentation of client-specific assistance and/or training rendered by the supervisor to a Companion Worker;

(4) All service logs;

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 90 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Companion Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

   a. Complaints which are made against Companion Workers will be investigated by the DSP and documented in the client's file.

   b. All complaints to be investigated will be referred to the Companion Worker Supervisor who will take appropriate action.

   c. The Companion Worker Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.

   d. The Companion Worker Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Service as well as in the contract with the Operating Agency, the DSP shall be required to adhere to the following stipulations:

1. The DSP shall designate an individual to serve as the administrator who shall employ qualified personnel and ensure adequate staff education, in-service training, and perform employee evaluations. This does not have to be a full-time position; however, the designated administrator will have the authority and responsibility for the direction of Companion Service for the DSP Agency. The DSP Agency shall notify the operating agency and the Alabama Medicaid Agency within three (3) working days in the event of a change in the administrator, address, telephone number, or of an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This shall be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. Administrative and supervisory functions shall not be delegated to another organization.

4. A list of the members of the DSP's governing body shall be available to the Operating Agency and the Alabama Medicaid Agency upon request.

5. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the waiver document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

6. The DSP shall acquire and maintain liability insurance during the life of this contract to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the DSP. Upon request, the DSP shall furnish a copy of the insurance policy to the Operating Agencies and the Alabama Medicaid Agency.
7. The DSP shall conform to applicable federal, state and local health and safety rules and regulations, and have an on-going program to prevent the spread of infectious diseases among its employee (such as making substitutions for ill Companion Workers and training Companion Workers in personal hygiene and proper food handling and storage).

8. The DSP shall maintain an office which will be open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide it's regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will assure that the service is rendered.

10. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

H. Provider Experience

Providers of Companion Service must meet all provider qualifications prior to rendering the Companion Service.

SCOPE OF SERVICE
FOR
HOME DELIVERED MEALS
ELDERLY/DISABLED WAIVER

A. Definition

Home Delivered Meals are provided to an eligible individual age 21 or older that is unable to meet his or her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

When specified in the Plan of Care, this service may include seven (7) or fourteen (14) frozen meals per week. A client may be authorized to receive seven (7) frozen meals plus seven (7) breakfast meals in lieu of fourteen (14) frozen meals. In addition, the service may include the provision of two (2) or more shelf-stable meals (not to exceed 6 meals per 6-month period) to meet emergency nutritional needs when authorized on the client's Plan of Care.

Home Delivered Meals is not an entitlement. Provision is based on the needs of the individual client.

B. Objective

The objective of Home Delivered Meal Service is to provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability or dependency, who require nutritional assistance to remain in the community, and who do not have a care giver available to prepare a meal for them.

C. Description of Service to be Provided

1. The unit of service is one (1) package of frozen or breakfast meals delivered once a week to a client's residence. Each package of meals contains seven (7) frozen meals or seven (7) breakfast meals. For shelf-stable meals, the unit of service is two (2) meals, packaged as individual meals and delivered to the client's residence. The types of meals available are:

   Frozen Meal--A frozen meal consists of an entree plus two (2) side dishes; fruit juice; bread; margarine; dessert; and milk. Meals are packed seven (7) meals/box and will contain the entree plus two (2) side dishes, juice, and margarine. Bread, dessert, and milk are delivered separately in the refrigerated or room temperature form.

Breakfast Meal--A breakfast meal consists of fortified cereal in an individual serving bowl: fruit or juice; bread; milk; and condiments (margarine, jelly, jam, cream cheese, peanut butter, syrup, etc.) All items are delivered in room temperature or refrigerated form. A meal pack will contain seven (7) meals.

Shelf-Stable Meal--A shelf-stable meal consists of an entree; fruit or vegetable juice; crackers or breadsticks; vegetable, soup, canned fruit, or dried fruit; cookie, snack cake, snack cracker, cereal, pudding, canned fruit, or dried fruit; and nonfat dry milk. A meal pack will contain a double shelf-stable meal. Shelf-stable meals may only be provided when frozen meals have also been authorized.

2. The number of units of service provided to each client is dependent upon the individual client's needs and is set forth in the client's plan of care, established by the Case Manager in consultation with the client. The client must be identified as having difficulty in shopping and/or preparing appropriate, nutritious meals. The client must have adequate and appropriate means for storing and heating frozen meals, be capable of performing the simple tasks associated with storing and heating a frozen meal, or have other appropriate arrangements approved by the Case Manager.

   a. Clients authorized to receive one (1) unit of service per week will receive one 7-pack of frozen meals.

   b. Clients authorized to receive two (2) units of service per week will receive two 7-packs of frozen meals or one 7-pack of frozen meals and one 7-pack of breakfast meals.

   c. The maximum number of meals authorized per week will be fourteen (14) meals.

   If the client attends an Adult Day Health (ADH) center five (5) days a week and receives two meals at the ADH center, the client will not be eligible for this service. If the client attends the center five (5) days a week and receive one meal daily at the ADH center, the client may receive one (l) pack of frozen meals per week, which equals to seven (7) meals. If the client attends the center less than five (5) days a week, the Case Manager should make sound judgement as to whether the client is eligible for the service. If a client receives meals-on-wheels five (5) days a week, they can receive two (2) packs of frozen meals per week, which equals to fourteen (14) meals. There must be a clear audit trail, which clearly defines how many meals the client receives.

3. Standard Diets

a. Menus must comply with the most recent Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture.

b. Each meal in a pack of frozen meals must provide a minimum of seven hundred (700) kilocalories. The mean level of the indicator nutrients per frozen meal in a pack of frozen meals must be equal to or higher than one-third (1/3) of the daily recommended dietary allowances (RDA) for adults as determined by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Home Delivered Meals service will not constitute a full daily nutritional regimen.

c. Menus for breakfast meals must be matched to menus for frozen meals. The combination of a breakfast meal and a frozen meal must provide at least one thousand two hundred (1200) kilocalories. The mean level of the indicator nutrients provided in a pack of frozen meals and a pack of breakfast meals must equal or exceed 2/3 of the RDA for adults.

d. While the individual has freedom of choice regarding this service, it is the responsibility of the Case Manager to ensure the appropriateness of the service and to ensure the client qualifies for the service. All clients eligible for this service must be given free choice of all qualified providers.

If, after careful review of the assessment information and discussion of the client's situation, the Case Manager does not think the Home Delivered Meals are appropriate for the individual, (or there are risks to the client associated with the meals), other options that will assist in meeting the nutritional needs of the client should be discussed with the client and documented in the case record. Should the client insist on the meals, providing they meet the other qualifying criteria, additional information should be secured from the physician. In the event the client continues to insist on meals against the Case Manager's and Physician's advice, the client has a right to make this choice. Documentation of the risk being taken by the client must be documented in the case record and discussed in detail with the client, responsible relative or friend, if available, and the physician.

4. Menu Requirements for Emergency Meals

a. Shelf-stable meals will be delivered at least every six (6) months to at-risk clients. Shelf-stable meals are to be used in the event of an emergency

when the DSP cannot deliver meals as scheduled. The number of units will be determined by the client's plan of care, not to exceed 6 meals per 6-month period.

b. All foods in the meal must be individually packaged food products that can be stored without refrigeration and that can be eaten with little or no preparation. The meal must provide a minimum of 700 kilocalories and one-third (1/3) of the RDA for the indicator nutrients for adults. Sodium content of the meals may be somewhat high because of the necessary reliance on commercially formulated food products.

c. Shelf-stable meals are intended for use solely in emergency situations.

5. All menus must be reviewed and approved by the Meals Services Coordinator, who is a Registered Dietitian licensed to practice in the State of Alabama and employed by the OA.

6. The DSP will provide a list of its regularly scheduled holidays to the OA, and the DSP will not be required to deliver meals on those days. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP will also provide the regular hours of business operation. Arrangements should be made by the DSP to see that clients do not go without a meal as a result of the holiday schedule.

7. The DSP must provide meals fifty-two (52) weeks a year. During holiday periods, meal delivery schedules may be adjusted per agreement between the OA and the DSP.

8. Service Standards

a. Each DSP must provide one (1) frozen meal per day, seven (7) days per week for fifty-two (52) weeks per year, and any additional authorized meals.

b. The facility at which the meals are prepared and/or packaged, as well as the manner of handling, transporting, serving and delivery of these meals, must meet all applicable health, fire, and safety and sanitation regulations.

c. No home canned or prepared food shall be used in preparation and service of the meals.

d. Primary meal components of frozen meals (entree plus two side dishes) must be produced at a food processing plant with United States

Department of Agriculture (USDA) approval or its equivalent in the state of Alabama. The DSP will furnish the OA with copy of said USDA approval or its equivalent in the state of Alabama to produce meals for the frozen meal program. Products must be quick frozen in a blast freezer or the equivalent.

e. Primary meal components shall be packaged in individual trays, properly sealed, and labeled with the contents and instruction for storage and preparation. Meal delivery boxes will be date stamped with the date of delivery to the client.

f. Primary meal components of frozen meals (entree plus two side dishes) must be packaged as single meal units in a container that are suitable for re-thermalization in a microwave or conventional oven at temperatures up to 400° F.

g. The DSP will be responsible for meal delivery to the client.

(1) Delivery routes must be clearly established. Meal packs must be delivered once weekly on days mutually agreed upon by the DSP and the OA. Clients will be informed of the delivery date and projected delivery time. The DSP must deliver meals within plus or minus two hours of projected delivery time and deliver all meal components to a client in a single stop.

(2) Cold food will be individually portioned. The only exception is that milk will be delivered in one half-gallon container for every service unit of frozen meals and breakfast meals. Cold food will be transported in approved insulated carriers which will maintain the required cold (45 degrees Fahrenheit or below) temperatures until the time of delivery to the client. Frozen meals must be transported in approved insulated carriers that will maintain the meals in a solid frozen state until the time of delivery to the client. Alternatively, a frozen meal delivery truck may be used to transport and deliver meals.

(3) Meal delivery must be documented with a signed delivery ticket. The client, family, friend, or neighbor must sign verifying that the meals were received or other mutually agreed upon electronic means of verification. Meals may not under any circumstance be left at a home if the intended client or the designated representative (family member, friend, or neighbor) is not available to receive them.

(4) The DSP will be responsible for notifying the client in the event of a change in the delivery day or projected delivery time. Because of the logistics involved in notifying all clients of a change in the delivery day, modification of the delivery day must be a last resort.

(5) Home Delivered Meals are provided for the benefit of the client and to meet client needs rather than others in the client's household.

D. Provider Certification Requirements

1. The DSP shall give initial and on-going training in the proper service, handling, and delivery of food to all staff. Proof of the training must be recorded in the personnel file.

2. The DSP must comply with all applicable statues, regulations, guidelines and policies at the local, State, and Federal levels including, but not limited to:

a. Food purchasing; food preparation and processing; food packaging and labeling; food storage, transport, and service; food safety; and food sanitation.

b. Equal Opportunity, Civil Rights, Affirmative Action, and Age Discrimination.

c. Fire and safety codes for both equipment and employees.

d. Use of Federal and State funds.

e. Client rights and confidentiality.

3. The DSP will procure and keep current any license, certification, permit, or accreditation required by local, State, or Federal statues or regulations and shall, upon request of the OA, submit proof of any such license, certification, permit or accreditation.

E. Procedure of Services

1. The DSP will initiate Home Delivered Meals on the date negotiated with the Case Manager and indicated on the Service Authorization Form. Services must not be provided prior to the authorized start date as stated on the Service Authorization Form.

a. The Case Manager will provide the DSP with the name, telephone number, address, driving directions, and an alternate contact for each client. Information will be sent to the DSP by fax or electronically.

b. Requests for adding up to five (5) new clients to an established delivery route should normally be accommodated by the DSP on the next scheduled delivery or within seven (7) calendar days.

c. Requests for major increases in clients, especially if it requires establishment of new delivery route(s), may require up to three (3) weeks advance written notice to the DSP.

2. Missed and Attempted Deliveries

a. A missed delivery occurs when the client or the person designated to receive the delivery is at the client's residence waiting for the meal delivery and the delivery is not made. In the event of a missed delivery, the DSP will advise the Case Manager by phone, fax, or electronically of the non-delivery of the meal pack. Notification must occur within twenty-four (24) hours of the non-delivery. The DSP must have an effective back-up service provision plan in place to ensure that the client receives the meals as authorized.

b. An attempted delivery occurs when the meals could not be delivered to a client because the client or designated representative was not available to accept delivery. In the event of an attempted delivery, the DSP will advise the Case Manager by phone, fax, or electronically of the non-delivery of the meal pack. Notification must occur within twenty-four (24) hours of the non-delivery. The Case Manager will be responsible for client follow-up and arranging emergency meals for at-risk clients.

c. The DSP may not bill for missed or attempted deliveries. If meals distributed to clients are later learned to be lacking components or to have contained components of unacceptable quality, payment to the DSP will be adjusted according to a schedule mutually agreed upon by the DSP and the OA.

d. The Case Manager will be responsible for instructing each client, both verbally and in writing**,** concerning the storage and preparation of the frozen and breakfast meals. This will also include written re-thermalization instructions.

e. If a client goes to the hospital or nursing home for a temporary stay and meals for this time period have been delivered, the Case Manager would be responsible for determining the date meal delivery should resume based on the number of complete meals still available to the client for consumption. If the temporary absence is anticipated, the meals can be cancelled in advance.

3. The DSP will notify the Case Manager by fax or electronically within three(3) working days of the following changes:

   a. Client's condition has changed and the Plan of Care no longer meets the client's needs or client no longer appears to need home delivered meal services.

   b. Client dies or moves out of service area.

   c. Client no longer wishes to participate in Home Delivered Meal Service.

   d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

   e. When services can no longer be provided.

4. The Case Manager will review a client's service plan within one (1) working day of receipt of a request from the DSP to modify service plan.

5. The DSP will maintain an electronic record keeping system that establishes an eligible client profile, in support of units of Home Delivered Meal Service provided, based on the Service Authorization Form.

6. The Case Manager will request Home Delivered Meal Services by designating the type meal, amount, frequency and duration of service for clients in accordance with the client's Plan of Care developed in consultation with the client. More than one meal for each day's consumption may be delivered if authorized by the client's Plan of Care. Requests for services will be transmitted electronically or by fax.

7. The OA will send notice by fax or electronically to the DSP immediately (within 24 hours of discovery) if a client becomes ineligible for services. The DSP will be responsible for terminating all further services upon receipt of notification.

8. The DSP must be able to provide meal delivery services in the designated service area within sixty (60) days after a new service contract is signed. Service contracts may be canceled by either the DSP or the OA, with or without cause.

Contracts may be canceled by the DSP by giving the OA not less than ninety (90) days written notice of intent to terminate services as of a specified date. Contracts may be canceled by the OA by giving the DSP not less than thirty (30) days written notice of intent to terminate services as of a specified date.

9. The OA will employ a Registered Dietitian licensed to practice in the State of Alabama to serve as Meals Services Coordinator. This individual will review and approve all menus, all food product specifications, all packaging materials and procedures, and delivery operations; provide nutritional oversight and monitoring, consultation and training assistance to the OA; and perform quality assurance activities.

10. Written instructions for distribution to clients regarding use of the meals will be developed by the Meals Services Coordinator. Written and verbal instructions will be provided by the Case Manager to the client/responsible person prior to the start of service. The Case Manager will monitor use of the meals.

F. Rights, Responsibilities, and Service Complaints

1. The OA has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of Home Delivered Meal Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency (AMA).

   a. Complaints which are made regarding the meals or DSP staff will be investigated by the Case Manager and reported to the DSP and Meals Services Coordinator. The problem will be resolved at the local level, if possible. If the problem can not be resolved at the local level, the Meals Services Coordinator will perform an investigation. All corrective action by the Case Manager or the Meals Service Coordinator will be documented and forwarded to the Director of the OA**.**

   b. The DSP will have procedures for the investigation and resolution of complaints.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and documentation showing that they have completed with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the OA and the AMA within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the AMA and the OA at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency, AMA, and the OA.

3. Administrative and supervisory functions shall **not** be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the OA and the AMA upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the OA and the AMA upon request.

6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the OA and/or the AMA.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the OA and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays the OA and the AMA. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the OA contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

11. A performance bond will be required of the DSP in the amount equal to the projected cost of one year's services provided by said DSP.

H. Provider Experience

Providers of Home Delivered Meals must meet all provider qualifications prior to rendering the Home Delivered Meals.

SCOPE OF SERVICE
FOR
PERSONAL CARE SERVICE
ELDERLY/DISABLED WAIVER

A. Definition

Personal Care Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

Personal Care Service is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

B. Objective

The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

Personal Care Service is to help waiver clients perform everyday activities when they have a physical, mental, or cognitive impairment that prevents them from carrying out those activities independently.

C. Description of Service to be Provided

1. The unit of service will be one (1) hour of direct PC Service provided in the client's residence. The number of units authorized per visit must be stipulated on the Plan of Care and the Service Authorization Form. The amount of time authorized does not include transportation time to and from the client's residence or the Personal Care Worker's break or mealtime.

2. The number of units and service provided to each client is dependent upon the individual client's needs as set forth in the client's Plan of Care established by the Case Manager.

Medicaid will not reimburse for activities performed which are not within the scope of service.

3. PC Service duties include:

a. Support for activities of daily living, such as,

- bathing
- personal grooming
- personal hygiene
- meal preparation
- assisting clients in and out of bed
- assisting with ambulation
- toileting and/or activities to maintain continence

b. Home support that is essential to the health and welfare of the recipient, such as,

- cleaning
- laundry
- home safety

Home safety includes a general awareness of the home's surroundings to ensure that the client is residing in a safe environment. Any concerns with safety issues will be reported to the PCW Supervisor as well as the Case Manager for follow-up.

c. Reporting observed changes in the client's physical, mental or emotional condition.

d. Reminding clients to take medication.

Note: Under no circumstances should any type of skilled medical or nursing service be performed by the PCW.

D. Staffing

The DSP must provide all of the following staff positions through employment or subcontractual arrangements.

PC Supervisors and PC Workers must be qualified, trained, and employed by a Medicare/Medicaid certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency.

1. Personal Care (P/C) Supervisors must be a licensed nurse(s) who meet the following requirements:

   a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

   b. Be a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is currently licensed by the Alabama State Board of Nursing to practice nursing.

   c. Have at least two (2) years experience as an RN or LPN in public health, hospital, or long term care nursing.

   d. Have the ability to evaluate the Personal Care Worker (PC Worker) in terms of his/her ability to carry out assigned duties and to relate to the client.

   e. Have the ability to coordinate or provide orientation and in-service training to PC Workers on either an individual basis or in a group setting.

   f. Have the ability to provide appropriate follow-up regarding a client/caregiver and/or Case Managers dissatisfaction, complaints or grievances regarding the provision of PC Service.

   g. Submit to a program for the testing, prevention, and control of tuberculosis annually.

   h. Possess a valid, picture identification.

2. PCWs must meet the following qualifications:

   a. Have references which will be verified thoroughly and documented in the Direct Service Provider personnel file. (References may include criminal background checks, previous employers, and/or aide register.)

   b. Be able to read and write.

c. Possess a valid, picture identification.

d. Be able to follow the Plan of Care with minimal supervision.

e. Assist client appropriately with activities of daily living as related to personal care.

f. Complete a probationary period determined by the employer with continued employment contingent on completion of a Personal Care in-service training program.

g. Must submit to a program for the testing, prevention, and control of tuberculosis annually.

3. Minimum Training Requirements for Personal Care Workers:

The Personal Care training program should stress the physical, emotional and developmental needs of the population served, including the need for respect of the client, his/her privacy, and his/her property. The minimum training requirement must be completed prior to initiation of service with a client. The DSP is responsible for providing/or conducting the training. The Personal Care training program must be approved by the Operating Agency and the Alabama Medicaid Agency. Proof of the training must be recorded in the personnel file.

Individual records will be maintained on each PCW to document that each member of the staff has met the requirements below.

Minimum training requirements must include the following areas:

a. Activities of daily living, such as,

- bathing (sponge, tub)
- personal grooming
- personal hygiene
- meal preparation
- proper transfer technique (assisting clients in and out of bed)
- assistance with ambulation
- toileting
- feeding the client

b. Home support, such as,

- cleaning
- laundry
- home safety

c. Recognizing and reporting observations of the client, such as,

- physical condition
- mental condition
- emotional condition
- prompting the client of medication regimen

d. Record keeping, such as,

- A service log signed by the client or family member/responsible person and PCW to document what services were provided for the client in relation to the Plan of Care.

- Submitting a written summary to the PCW Supervisor of any problems with client, client's home or family. The Supervisor in return should notify the Case Manager.

e. Communication skills

f. Basic infection control/Universal Standards

g. First aid emergency situations

h. Fire and safety measures

i. Client rights and responsibilities

j. Other areas of training as appropriate or as mandated by Medicaid, or the Operating Agency

4. The DSP will be responsible for providing a minimum of twelve (12) hours of relevant in-service training per calendar year for each PC Worker. In-service training is in addition to PC Worker orientation training. For PC Workers hired during the calendar year, this in-service requirement may be prorated based on date of employment as a PC Worker.

5. Documentation of the training provided shall include topic, date, name and title of trainer, objective of the training, outline of content, length of training, list of trainees and location.

6. Topics for specific in-service training may be mandated by Medicaid or the Operating Agency.

7. In-service training may entail demonstration of providing care to the client. Additional training may be provided as deemed necessary by the DSP. Any self-study training programs must be approved for content and credit hours by Medicaid and the Operating Agency, prior to the planned training and may not exceed four(4) of the twelve(12) in-service annual training hours. The DSP shall submit proposed program(s) to the Operating Agency at least forty-five (45) days prior to the planned implementation.

8. The DSP must have an ongoing infection control program in effect and training on Universal Standards and an update on infection control shall be included as part of the twelve (12) hours required in-service for all PC Workers each calendar year.

9. The DSP Agency shall maintain records on each employee, which shall include the following:

    a. Application for employment;

    b. Job description;

    c. Record of health (annual tuberculin tests);

    d. Record of pre-employment and in-service training;

        (1) For PC Supervisor validation of required CEUs for licensure will be accepted.

    e. Orientation;

    f. Evaluations;

    g. Supervisory visits;

    h. Copy of photo identification;

    i. Records of all complaints/incidents lodged by the

client/family/responsible party and action taken;

j. Reference contacts;

k. Other forms as required by state and federal law, including agreements regarding confidentiality.

E. Procedures for Service

1. The Case Manager will submit a Service Authorization Form and Plan of Care to the DSP Agency authorizing Personal Care Service and designating the units, frequency, beginning and ending dates of service, and types of duties in accordance with the individual client's needs.

2. The DSP Agency will initiate PC Service within three (3) working days of receiving the Service Authorization Form in accordance with the following:

   a. Services must **not** be provided prior to the authorized start date as stated on the Service Authorization Form.

   b. The DSP Agency will adhere to the services and schedule as authorized by the Case Manager on the Service Authorization Form. No payment will be made for services unless authorized and listed on the Plan of Care.

3. Provision of Service Authorized:

   a. Personal Care Service cannot be provided at the same time other authorized waiver services are being provided.

   b. Personal Care Workers will maintain a separate service log for each client to document their delivery of services.

      (1) The Personal Care Worker shall complete a service log that will reflect the types of services provided, the number of hours of service, and the date and time of the service.

      (2) The service log must be signed upon each visit by the client, or family member/responsible party and the PC Worker. In the event the client is not physically able to sign and the family member/responsible party is not present to sign, then the Personal Care Worker must document the reason the log was not signed by the client or family member/responsible party.

(3) The service log will be reviewed and signed by the Personal Care Supervisor at least once every two (2) weeks. Service logs will be retained in the client's file.

(4) Client visits may be recorded electronically via telephony. Electric documentation will originate from the client's residence as indicated by the phone number at the residence. A monthly report of phone number exceptions will be maintained with written documentation giving the reason the electronic documentation did not originate at the client's residence, e.g., phone line down, client does not have phone, client staying with relatives. These electronic records may be utilized in place of client signatures.

c. Services provided by relatives or friends may be covered only if relatives or friends meet qualifications for providers of care. However, providers of service cannot be a parent/step-parent/legal guardian of a minor or a spouse of the individual receiving services, when the services are those that these persons are legally obligated to provide.

4. Monitoring of Service:

PC Service must be provided under the supervision of the registered nurse or licensed practical nurse who meets the requirements of D.1. and will:

a. Make the initial visit to the client's residence prior to the start of PC Service for the purpose of reviewing the Plan of Care.

The initial visit should be held at the client's place of residence and should include the Case Manager, the PC Supervisor, the client, and the caregiver, if feasible. It is advisable to also include the PC Worker in the initial visit.

b. Be immediately accessible by phone during the time PC Service is being provided. Any deviation from this requirement must be prior approved in writing by the Operating Agency and the Alabama Medicaid Agency. If this position becomes vacant the Operating Agency and the Alabama Medicaid Agency must be notified within 24 hours when the position becomes vacant.

c. Provide and document supervision of, training for, and evaluation of PCWs according to the requirements in the approved waiver document.

d. Provide on-site (client's residence) supervision of the PCW at a minimum of every sixty (60) days for each client. Supervisory visits must be documented in the individual client record and a copy placed in the worker's personnel file. Supervisors will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the PCW. In the event the on-site supervisory visit cannot be completed in a timely manner due to the client's being inaccessible, the supervisory visit must be completed within five (5) working days following resumption of Personal Care Service. Documentation regarding this action should be in the DSP client record.

e. The DSP must complete the sixty (60) day supervisory review which includes, at a minimum, assurance that the services are being delivered consistent with the Plan of Care and the Service Authorization Form in an appropriate manner, assurance that the client's needs are being met, and a brief statement regarding the client's condition. The summary must be submitted to the Case Manager within ten (l0) calendar days after the sixty (60) day supervisory review. In the event the client is not available during the time the visit would have normally been made, the review must be completed within five (5) working days of the resumption of PC Service.

f. Assist PCWs as necessary as they provide individual Personal Care Service as outlined in the Plan of Care. Any supervision/ assistance given must be documented in the individual client's record.

g. The PC Supervisor must provide direct supervision of each PC Worker with at least one (1) assigned client at a minimum of every six (6) months. Direct supervisory visits must be documented in the PC Worker's personnel record.

(1) Direct supervision may be carried out in conjunction with an on-site supervisory visit.

The PC Supervisor will provide and document the supervision, training, and evaluation of PC Workers according to the requirements in the approved Waiver Document.

5. Missed Visits and Attempted Visits

a. Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Personal Care Worker is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary/or reduced by the DSP.

Clients who are designated by the Case Manager as being at-risk should be given first priority when Personal Care Service visits must be temporarily prioritized and

(a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Personal Care Worker.

(3) The DSP will document missed visits in the client's files.

(4) Whenever the DSP determines that services cannot be provided to an at-risk client as authorized, the Case Manager must be notified by telephone immediately. All missed/attempted visits for one week and the reason for the missed/attempted visit must be reported in writing on the **"Weekly Missed/Attempted Visit Report"** form to the Case Manager on Monday of each week. Any exception to the use of this form must be approved by the Operating Agency and the Alabama Medicaid Agency.

(5) The DSP may **not** bill for missed visits**.**

b. Attempted Visits

(1) An attempted visit occurs when the PCW arrives at the home and is unable to provide services because the client is not at home or refuses services.

(2) If an attempted visit occurs:

(a) The DSP may **not** bill for the attempted visits.

(b) The Supervisor will contact the client to determine the reason why the client was not present or why

services were refused. Documentation of this discussion must be in the client's file.

(c) The DSP will notify the Case Manager promptly whenever an attempted visit occurs.

6. Changes in Services

a. The DSP will notify the Case Manager within one (1) working day of the following changes:

(1) Client's condition and/or circumstances have changed and the Plan of Care no longer meets the client's needs:

(2) Client does not appear to need Personal Care Service;

(3) Client dies or moves out of the service area;

(4) Client indicates Personal Care Service is not wanted; and,

(5) Client loses Medicaid financial eligibility;

(6) When services can no longer be provided.

b. The Case Manager will notify the DSP immediately if a client becomes medically or financially ineligible for waiver services.

c. If the DSP identifies additional duties that may be beneficial to the client's care, but are not specified on the Plan of Care, the DSP shall contact the Case Manager to discuss having these duties added.

(1) The Case Manager will review the DSP's request to modify services and respond within one (1) working day of the request.

(2) The Case Manager will approve any modification of duties to be performed by the PCW and re-issue the Service Authorization Form accordingly.

(3) Documentation of any change in a Plan of Care will be maintained in the client's file.

(a) If the total number of hours of service is changed, a new Service Authorization Form is required from the Case Manager.

(b) If the types or times of services are changed, a new Service Authorization Form is required from the Case Manager.

(c) If an individual declines PC Service or has become ineligible for services, a Service Authorization Form for termination is required from the Case Manager.

7. Documentation and Record-Keeping

a. The DSP shall maintain a record keeping system for each client that documents the units of service delivered based on the Service Authorization Form. The client's file shall be made available to Medicaid, the operating agencies, or other agencies contractually required to review information upon request.

The DSP shall maintain a file on each client, which shall include the following:

(1) A current HCBS application;

(2) Both current and historical Service Authorization Forms specifying units, services, and schedule of Personal Care visits for the client;

(3) Documentation of client specific assistance and/or training rendered by the Supervisor to a Personal Care Worker;

(4) All service logs;

(a) The service log must be reviewed and initialed by the Nurse Supervisor at least once every two (2) weeks.

(5) Records of all missed or attempted visits;

(6) Records of all complaints lodged by clients or family members/responsible parties and any actions taken; and,

(7) Evaluations from all 60 day on-site supervisory visits to the client;

(8) The Service Authorization Form notifying the DSP Agency of termination, if applicable;

(9) Initial visit for in-home services;

(10) Any other notification to Case Manager;

(11) Permission statements to release confidential information, as applicable.

b. The DSP will retain a client's file for at least five (5) years after services are terminated.

c. The DSP Agency shall comply with federal and state confidentiality laws and regulations in regard to client and employee files.

F. Rights, Responsibilities, and Service Complaints

1. The Operating Agency has the responsibility of ensuring that the DSP has fulfilled its duty of properly informing the client of all rights and responsibilities and the manner in which service complaints may be registered.

2. The DSP Agency will inform the client/responsible party of their right to lodge a complaint about the quality of PC Service provided and will provide information about how to register a complaint with the Case Manager as well as the Alabama Medicaid Agency.

a. Complaints which are made against PCW will be investigated by the DSP Agency and documented in the client's file.

b. All complaints which are to be investigated will be referred to the PCW Supervisor who will take appropriate action.

c. The PCW Supervisor will take any action necessary and document the action taken in the client's and/or the employee's files, whichever is most appropriate based on the nature of the complaint.

d. The PCW Supervisor will contact the Case Manager by letter or telephone about any complaint and any corrective action taken.

3. The DSP must maintain documentation of all complaints, follow-up, and corrective action regarding the investigation of those complaints and

documentation showing that they have complied with the requirements of this section.

G. Administrative Requirements

In addition to all conditions and requirements contained in the Scope of Services as well as in the contract, the DSP shall be required to adhere to the following stipulations:

1. The DSP Agency shall designate an individual to serve as the agency administrator who shall employ qualified personnel and ensure adequate staff education, in-services training and perform employee evaluations. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the DSP Agency. The DSP Agency shall notify the Operating Agency and the Alabama Medicaid Agency within three (3) working days of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The DSP will maintain an organizational chart indicating the administrative control and lines of authority for the delegation of responsibility down to the "hands on" client care level staff shall be set forth in writing. This information will be readily accessible to all staff. A copy of this information shall be forwarded to the Alabama Medicaid Agency and the Operating Agency at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the DSP Agency and to the Alabama Medicaid Agency and the Operating Agency.

3. Administrative and supervisory functions shall **not** be delegated to another agency or organization.

4. A list of the members of the DSP's governing body shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

5. The DSP Agency must maintain an annual operating budget which shall be made available to the Operating Agency and the Alabama Medicaid Agency upon request.

6. The DSP Agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the DSP Agency shall furnish a copy of the insurance policy to the Operating Agency and/or the Alabama Medicaid Agency.

7. The DSP Agency shall ensure that key agency staff, including the agency administrator or the DSP Supervisor, be present during compliance review audits conducted by Medicaid, the Operating Agency and/or its agents.

8. The DSP Agency shall maintain an office which is open during normal business hours and staffed with qualified personnel.

9. The Direct Service Provider (DSP) shall provide its regularly scheduled holidays to the Operating Agency and the Alabama Medicaid Agency. The DSP Agency must not be closed for more than four (4) consecutive days at a time and then only if a holiday falls in conjunction with a weekend. The DSP shall also provide the regular hours of business operation. If a service is needed on a scheduled holiday, the service provider will ensure that the service is rendered.

10. The DSP Agency will maintain a Policy and Procedures Manual to describe how activities will be performed in accordance with the terms of the Operating Agency contract and the Waiver Document. The Policy and Procedure Manual should include the organization's Emergency Plan regarding service delivery.

H. Provider Experience

Providers of Personal Care Service must meet all provider qualifications prior to rendering the Personal Care Service.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid Agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_X_ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid Agency.

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2.__X__SSI recipients (SSI Criteria States and 1634 States).

3.____ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.__X__Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6.__X__The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

____ A. Yes ___B. No

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b._X_ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)_X_ A special income level equal to:

____ 300% of the SSI Federal benefit (FBR)

100% of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8._X_ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

SSI RELATED PROTECTED GROUPS DEEMED TO BE MEDICAID ELIGIBLE

These groups would include:

1. Continuous - Those individuals who are not eligible for SSI because their income exceed the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977 ("Pickle People") (42 CFR 435.135).

2. Disabled Widow/Widower - A widow/widower between the ages of **50 and 59** who would be eligible for SSI except for entitlement to Social Security resulting from a change in the definition of disability and who are not eligible for Part A Medicare (P.L. 99-27251202 and P.L. 100-203, S 9108).

3. Diabled Widow/Widower - A widow/widower between the ages of **60 and 65** who lost SSI as a result of receiving Social Security and who are not receiving Medicare (P.L. 100-203, S9116).

4. Disabled Adult Child - An individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child (P.L. 99-643).

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. . **435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. X The following standard included under the State plan (check one):

(1) X SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5) X Other (specify):
Deemed SSI; See Attachment C-1-a

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F.___ The amount is determined using the following formula:

G._X_ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State□s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of standard.

E.___ The amount is determined using the following formula:

F.___ Other

G._X_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)___**209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. X The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level:____%

(5) X Other (specify): See Attachment C-1-a

B.___ The following dollar amount:
$____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.___ The following formula is used to determine the amount:

F._X_ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:

$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G._X_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

SPOUSAL POST ELIGIBILITY

2.____ The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)_X_ Other (specify): Not Applicable

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

See Attachment D - "Description of Medical Evaluation of Level of Care"

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

_X_ Physician (M.D. or D.O.)

_X_ Registered Nurse, licensed in the State

X Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months
_X_ Every 12 months
___ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

QUALIFICATIONS AND RESPONSIBILITIES OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The Alabama Medicaid Agency develops the level of care criteria used to determine the individual's needs for Elderly and Disabled Waiver services. The case manager will be trained by staff from the Alabama Medicaid Agency and the Operating Agencies in the use of the level of care criteria.

The case manager must meet the following educational requirements:

Bachelor of Arts degree or a Bachelor of Science degree from an accredited college or university, preferably in a human services related field, or;

Bachelor of Arts degree or a Bachelor of Science degree from an accredited School of Social Work, or;

RN licensure within the State of Alabama

The Alabama Department of Public Health and the Alabama Department of Senior Services employ case managers who are responsible for conducting the initial level of care evaluations for individuals applying for admission and readmission to the Elderly and Disabled Waiver.

The case manager will perform the initial assessment and completes the level of care evaluation. The completed assessment will be forwarded to the individual's attending physician for the completion of the medical certification. The attending physician will review and sign the medical certification on the assessment indicating that the individual requires the institutional level of care.

The assessment including the physician's certification is then forwarded to the Operating Agency for review by a registered nurse who will conduct a 100% review of applications to ensure the medical appropriateness and the level of care determination. If the Operating Agency determines that the documentation does not support the individual's need for the level of care as determined by the case manager and the attending physician, the documentation will be forwarded to the Alabama Medicaid Agency for a physician review. The Alabama Medicaid Agency's staff physician will make the final decision of approval or denial based upon the documentation. If a denial is issued the recipient will receive a notice informing them of their right to an informal conference and/or a fair hearing.

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_X_ "Tickler" file

___ Edits in computer system

_X_ Component part of case management

___ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid Agency in its central office

___ By the Medicaid Agency in district/local offices

X By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

X By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

X By service providers

___ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 5 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION / ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

      c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

      d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

DISSATISFACTION OF SERVICES

REQUEST CONFERENCE OR REVIEW OF CASE

A person may notify the Alabama Medicaid Agency giving the reason for the dissatisfaction and ask for either a conference or a review of the case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney or other spokesperson of their choice.

REQUEST A FAIR HEARING

A written request for a hearing must be filed within sixty (60) days following the action with which he is dissatisfied. He, his legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for a hearing is made by someone other than the person who wishes to appeal, the hearing must make a definite statement that he has been authorized to do so by the persons for whom the hearing is being requested. Information about hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the persons will be arranged. If the person is satisfied before the hearing and wants to withdraw his request, he or his legally appointed representative or other authorized person should write the Alabama Medicaid Agency indicating that he wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy, which requires an automatic change adversely affecting some or all recipients.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination, unless there are unnecessary delays by the person requesting the hearing for this representative. If benefits are continued pending the outcome of the hearing and the Hearing Officer decided that termination was proper, the Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

MEDICAID ELIGIBILITY DIVISION POLICIES AND PROCEDURES IN COMPLIANCE WITH CIVIL RIGHTS ACT OF 1964 AND SECTION 504 OF THE REHABILITATION ACT OF 1973

I have reviewed and been given a copy of my right to a Medicaid review of the case and/or a Fair Hearing.

_____ _____

(Recipient and/or Legal Representative) (Date)

HEARINGS AND APPEALS

In accordance with 42 C.F.R. 431.211, the individual must receive at least a ten (10) day advance notice of the termination of services, reduction of services, or change in the type of services to be provided under the waiver. If the individual is dissatisfied with the action taken, the Alabama Medicaid Agency will provide an opportunity for an informal conference or review of their case by the Alabama Medicaid Agency. At the conference, the person may present the information or may be represented by a friend, relative, attorney, or other spokesperson of their choice.

The Alabama Medicaid Agency will provide an opportunity for a fair hearing under 42 C.F.R. Part 431 Subpart E for individuals who are still dissatisfied after the above procedure has been completed. A written request for a hearing must be filed within sixty (60) days following the action with which he/she is dissatisfied. He/she, his/her legally appointed representative or other authorized person must request the hearing and give a correct mailing address. If the request for the hearing is made by someone other than the person who wishes to appeal, the person requesting the hearing must make a definite statement that he/she has been authorized to do so by the person for whom the hearing is being requested. Information about the hearings will be forwarded and plans will be made for the hearing and a date and place convenient to the person will be arranged. If the person is satisfied before the hearing and wants to withdraw his/her request, he/she or his/her legally appointed representative or other authorized person should write the Alabama Medicaid Agency that he/she wishes to do so and give the reason for withdrawing.

The Alabama Medicaid Agency need not grant a request for a hearing if the sole issue is a federal or state law or policy which requires an automatic change adversely affecting some or all recipients.

When benefits are terminated, they can be continued if a hearing request is received within ten (10) days following the effective date of termination. If benefits are continued pending the outcome of the hearing and the Hearing Officer decides that termination was proper, Alabama Medicaid Agency may recover from the terminated recipient or sponsor, the costs of all benefits paid after the initial termination date.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Appendix D-4-a

CERTIFICATE OF CHOICE

Title XIX Home and Community Based Waiver
for
Elderly and Disabled Waiver

*Under the provisions of Alabama's Waiver, in accordance with the Social Security Act, as amended, applicants for waiver services or a designated responsible party with authority to act on the applicant's behalf will, when the applicant is found eligible for waiver services, be offered the alternative of home and community based services or institutional services.

Program: _____

Client's Name: _____

Client's Medicaid Number: _____

I have been given a choice between Community Services and nursing home care and I have chosen Community Services.

Signed: _____
(Recipient)
Witness: _____
Date: _____

Signed: _____ Witness: _____
(Patient Representative)

_____
(Relationship)

Date: _____

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

__ Social Worker (qualifications attached to this Appendix)

X Case Manager

___ Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid Agency central office

___ At the Medicaid Agency county/regional offices

X By case managers

X By the agency specified in Appendix A

___ By consumers

X Other (specify): Direct Service Provider

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine

the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

__ Every 6 months

X Every 12 months

___ Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid Agency:

PLAN OF CARE DEVELOPMENT

The following is a description of the process by which the Plan of Care is developed.

The Alabama Medicaid Agency develops the level of care criteria and the Plan of Care (POC) document.

The Alabama Medicaid Agency along with the Operating Agencies (OA) provides case management training related to the assessment of the individual and the method of developing the Plan of Care based on specific individual's needs.

The POC will include the types of service, the number of units of service, the frequency and duration of each service, and the provider of each service.

The OA will designate a registered nurse to review and approve both the Plan of Care and the level of care assessment prior to initiating service delivery. The OA nurse will ensure that all federal and state requirements are met prior to initiating service delivery.

The Alabama Medicaid Agency's, Long Term Care Division will perform a retrospective review of a 25% sample of approved applications to include the POC and the client assessment.

The Alabama Medicaid Agency's, Long Term Care Quality Assurance Unit will conduct onsite reviews of direct service providers, including the POC, and the client assessment to ensure compliance with the level of care and delivery of services included on the POC.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid Agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid Agency and each provider of services under the waiver.

3. Method of payments (check one):

X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

b . BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

a. When the individual was eligible for Medicaid waiver payment on the date of service;

b. When the service was included in the approved plan of care;

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

____ Yes

__X__ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

__X__ All claims are processed through an approved MMIS.

____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

____ The Medicaid Agency will make payments directly to providers of waiver services.

__X__ The Medicaid Agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

____ The Medicaid Agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

X__ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will **not** be required to do so. Direct payments will be made using the following method:

Waiver claims from these providers will be submitted to the same Medicaid Fiscal Agent used by the rest of the Medicaid programs using unique provider numbers and service indicators for tracking. These claims will be adjudicated and paid by the Medicaid Fiscal Agent.

2. Interagency agreement(s) reflecting the above arrangements are on file at the edicaid Agency.

DESCRIPTION OF THE BILLING PROCESS

(1) For dates of service beginning October 1987 (FY-88) and after, payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/87 to 11/15/87 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) The basis for the fees will usually be based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(5) The Operating Agencies (OA), as specified in the approved waiver document, are governmental agencies and will receive actual cost for services rendered. The actual fee for service may differ among OAs. OAs have 120 days from the end of the waiver year to submit claims for services rendered. No claims for services in any given waiver year will be processed beyond 120 days after the end of that waiver year.

(6) Accounting for actual cost and units of services provided during a waiver year must be captured on HCFA Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

(7) The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in

twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

(8) The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS).

(9) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

(10) There must be a clear differentiation between waiver services and nonwaiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: NF

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$7,618	$5,583	$20,181	$2,988
2	$7,983	$5,851	$21,150	$3,131
3	$8,402	$6,132	$22,165	$3,281
4	$8,769	$6,426	$23,229	$3,438
5	$9,190	$6,734	$24,344	$3,603

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	7500
2	7500
3	7500
4	7500
5	7500

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NF

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: NF

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: NF

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver# ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___X_ Other (specify): Based on data shown by the HCFA-372 Report, Waiver #068, for Waiver Year 2001, with a 4.8 percent inflation factor applied to each year of the renewal period.

APPENDIX G-6

FACTOR G

LOC: NF

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

____ Based on trends shown by HCFA Form 372 for years ____of waiver #____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__x__ Other (specify): Based on data shown by the HCFA-372 Report, Waiver #068, for Waiver Year 2001, with a 4.8 percent inflation factor applied to each year of the renewal period.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: NF

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

____ Based on HCFA Form 372 for years ____ of waiver# ____, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__x__ Other (specify): Based on data shown by the HCFA-372 Report, Waiver #068, for Waiver Year 2001, with a 4.8 percent inflation factor applied to each year of the renewal period.

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF

YEAR 1

FACTOR D:	$7,618		FACTOR G: $20,181
FACTOR D':	$5,583		FACTOR G': $2,988
TOTAL:	$13, 201	≤	TOTAL: $23,169

YEAR 2

FACTOR D:	$7,983		FACTOR G: $21,150
FACTOR D':	$5,851		FACTOR G': $ 3,131
TOTAL:	$13,834	≤	TOTAL: $24,281

YEAR 3

FACTOR D:	$8,402		FACTOR G: $22,165
FACTOR D':	$6,132		FACTOR G': $ 3,281
TOTAL:	$14,534	≤	TOTAL: $25,446

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: NF

YEAR 4

FACTOR D:	$8,769		FACTOR G:	$ 23,229
FACTOR D':	$6,426		FACTOR G':	$3,438
TOTAL:	$15,195	≤	TOTAL:	$26,667

YEAR 5

FACTOR D:	$9,190		FACTOR G:	$24,344
FACTOR D':	$6,734		FACTOR G':	$3,603
TOTAL:	$15,924	≤	TOTAL:	$27,949